U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue date: 04Sep2002

CASE NO.: 2001-BLA-0777

In the Matter of:

CLARENCE O. CRITES
Claimant

v.

CONSOLIDATION COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Robert F. Cohen, Esquire
For the Claimant

William S. Mattingly, Esquire
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER ON MODIFICATION – DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 20 C.F.R. § 718.201(a). It is commonly known as black lung.

A formal hearing was held in Morgantown, West Virginia on November 27, 2001, at which time all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in his Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-107, Claimant's exhibits (CX) 1-8, and Employer's exhibits (EX) 1-9 were admitted into evidence. The following post-hearing exhibits have been made part of the record: EX 10 – the deposition transcript of Dr. James R. Castle, and EX 11 – the deposition transcript of Dr. Joseph J. Renn, III.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They are also based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in the decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

ISSUES

I. Whether the claim was timely filed?

II. Whether there is a change in condition[1] or mistake in fact?

III. Whether the miner suffers from pneumoconiosis?

IV. Whether the miner's pneumoconiosis arose out of coal mine employment?

V. Whether the miner is totally disabled?

VI. Whether the miner's total disability is due to pneumoconiosis?

The issue raised by the employer pertaining to the constitutionality of the regulations was not litigated at the hearing and is preserved for appeal purposes only. (Tr. 36).

[1]Employer submits in its closing argument that Claimant is only alleging a mistake in fact. Employer's brief at 9. Claimant submits in his brief on page 19 that he is alleging both a mistake in fact and a change in condition. Upon inspection of the hearing transcript, I conclude that although Claimant's counsel stated that he is claiming a mistake in fact, he is also stating that a change in condition is implied. Tr. 35. Based upon this and his closing brief, I will analyze the case for both issues.

FINDINGS OF FACT AND CONCLUSIONS OF LAW[2]

Procedural History and Factual Background

Procedural History

Claimant initially filed his claim for benefits on December 6, 1989. (DX1) The claim was denied by the District Director (DX 21), and following a hearing on December 6, 1990, Administrative Law Judge (ALJ) Stuart A. Levin denied the claim in a Decision and Order issued on August 1, 1991. (DX 56) Claimant appealed this decision to the Benefits Review Board ("Board") which remanded the case to ALJ Levin by Decision and Order on April 20, 1994. (DX 50, 56) ALJ Levin subsequently issued a Decision and Order Denying Benefits on Remand on July 10, 1995. (DX 67) Claimant again appealed and the Board affirmed the denial of benefits by Decision and Order dated May 29, 1997. (DX 82) Claimant appealed further, to the U.S. Court of Appeals for the Fourth Circuit, which affirmed the denial of benefits on September 17, 1999. (DX 84)

Claimant submitted a request for modification within one year from the Fourth Circuit's decision on September 14, 2000. (DX 85) The District Director denied the request on January 19, 2001 (DX 97) and Claimant submitted a request for reconsideration which the District Director denied on January 24, 2001. (DX 100) The claim was referred to the Office of Administrative Law Judges for a hearing on May 4, 2001. (DX 106)

Background

Claimant was born March 1, 1925, and married his wife, Velda, on August 17, 1952. (DX 1) At the hearing, Claimant testified as follows: he worked for Consolidation Coal Company for about nineteen years.[3] All but one of the miner's years of coal mine employment was underground. This year was spent in shaft construction. Tr. 38. Claimant's last work for Employer was as a general inside laborer. Tr. 38. In this capacity, Claimant testified that he would lay track, sweep and shovel belts, carry blocks to build stoppings near the dust. Claimant testified that sweeping belts involved getting a stick and tying a "piece of braddish on it where the coal dust settles on top of the rock dust" and sweeping that. Tr. 39. Claimant shoveled as

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[2] The following abbreviations have been used in this decision and order: Tr. = transcript of hearing; BCR = board certified radiologist; B = B-reader.

[3] Claimant initially stated that he had 38 years of coal mine employment; however, he subsequently informed counsel that he was mistaken and that the UMWA Health and Retirment Funds had given him credit for 27-1/2 years of coal mine employment. As it was not possible to go back to the place in the transcript during the hearing and amend this information, the parties executed a stipulation containing this information.

much as an entire shift and carried blocks weighing 45 to 50 pounds. Claimant also carried cribs five or six blocks to build a stopping and carried up to 20 foot timber, as well. Tr. 39. Claimant testified that he was carrying 100 pounds or more. Tr. 39. He frequently carried rock dust bags, which initially weighed 100 pounds, but were reduced to 50 pounds. Tr. 40. He had trouble breathing during his last few years of work and got help from other workers. Tr. 40.

Claimant testified that he received treatment from the Fairmont Clinic and Dr. Schroering for quite a while and is currently seeing Dr. Abrahams regularly for lung problems, about three or four times a year. Tr. 41-42. Claimant remarked that he gets out of breath while carrying things about 40 or 50 pounds, or groceries, and wheezes on exertion. Tr. 42. He does not have problems with coughing. Tr. 43, 50. Claimant received state black lung benefits from West Virginia. Claimant was told he is disabled from black lung disease, but is unclear as to when he was told this. Tr. 46. Claimant testified that he never smoked cigarettes but chewed tobacco. Tr. 46, 49. Claimant is no longer bothered by dizziness, since he had a stent placed in his neck. Tr. 47. Claimant is on medications to help his breathing, which include Advair, and Eucalid. Tr. 48.

Timeliness of Claim

Claimant's Motion to Strike Portion of Employer's Brief

Employer submits in its closing brief that the instant claim is untimely because it was filed more than three years after the claimant was informed by a physician that he was totally disabled due to pneumoconiosis. (Employer's Post-Hearing Brief at pp. 4-8; Tr. 36, 43-46). By motion dated February 20, 2002, Claimant's counsel requests that the portion of Employer's brief addressing the issue of timeliness be struck. In support of this motion, Claimant submits that this issue has not been properly preserved by the employer and that the brief contained a major misstatement that the testimony which employer's counsel elicited on cross-examination was not clarified by the claimant on re-direct examination.

By letter dated February 26, 2002, counsel for Employer opposed Claimant's request to strike a portion of its brief or to find Claimant's testimony during re-direct examination relevant to any determination of when [Claimant] was informed by a physician that he had a disability due to pneumoconiosis.

The Regulations at Section 725.463 provide, in pertinent part:

> a) Except as otherwise provided in this section, the hearing shall be confined to those contested issues which have been identified by the district director...or any other issue raised in writing before the district director.

> b) An administrative law judge may consider a new issue only if such issue is not reasonably ascertainable by the parties at the time the claim was before the district director. Such new issue may be raised upon application of any party, or upon an administrative law judge's own motion, with notice to all parties, at any time after a claim has been transferred by the district director to the Office of Administrative Law Judges and prior to decision by an administrative law judge.

In the instant case, the issue of timeliness was listed on the controversion form filed by the Employer on December 26, 1989 and also when the case was initially referred to the Office of Administrative Law Judges on June 15, 1990. (DX 24, 28) However, it was never subsequently raised or addressed in its numerous dispositions, beginning with the hearing before Administrative Law Judge Levin, nor in its appeals before the Board and the Fourth Circuit Court of Appeals. While Employer may be correct that the timeliness issue was preserved in the earlier dispositions of the case, it should be noted that the issue was not listed, after Claimant filed his request for modification, on the May 4, 2001 controversion form CM-1025. Employer also did not raise the issue of timeliness between transmittal of the case to this office and the hearing, but did list it as an issue in its pre-hearing report and at the hearing.

In its Motion, Claimant's counsel states that he did not receive the pre-hearing report until the time of the hearing, and that for the employer to raise the issue of timeliness at the hearing for the first time, without any prior notice of it, constitutes unfair surprise. I agree that this could constitute unfair surprise, but I also take into consideration that Claimant's counsel did not object to this delay in receiving the pre-hearing report, nor make reference to it in the record, and therefore, it is not evident why Claimant's counsel did not receive the pre-hearing report prior to the hearing. Moreover, I also note that Claimant's counsel did not object when timeliness was raised at the hearing by Employer's counsel, subsequent to my summarization of the issues. Tr. 36.

Section 725.463 (b) also states that "the administrative law judge may, in his... discretion... hear and resolve the new issue..." Inasmuch as Claimant's counsel did not object to the late receipt of the pre-hearing report, nor to the issue when it was raised, I decline to strike those portions of the employer's brief and Claimant's motion is denied. I have, however, carefully considered Employer's arguments and find that it has not rebutted the presumption the miner's claim was timely filed.

Timeliness–Rebuttable Presumption

The Regulations provide that a claim for benefits "shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner..." and "There shall be a rebuttable presumption that every claim for benefits is timely filed." 20 C.F.R. § 725.308 (a) and (c). It is not clear when the miner was first informed that there was a medical determination that he was totally disabled due to pneumoconiosis.

Employer's counsel submits in its opposition letter that I not find Claimant's "testimony during re-direct examination relevant to any determination of when [Claimant] was informed by a physician that he had a disability due to pneumoconiosis", because Claimant testified that he was told he was disabled by black lung disease in 1984, no questions were asked about this by Claimant's attorney on redirect, and Claimant gave a non-responsive answer to a compound question by Claimant's counsel. Specifically, Claimant's counsel inquired whether Claimant was "unable to do your work while you were still working or that you had some impairment while working?" Tr. 50. I find Employer's arguments unpersuasive for the following reasons:

First, it is not clear from Claimant' s testimony that he was told he was disabled due to black lung disease in 1984. Employer cites the following passage from the transcript:

Q: Do you remember, during that process, when a, when a doctor first told you, you were disabled by black lung disease?

A: No, sir, I don't.

Q: Could it have been Dr. Patel back in 1979 or 1980?

A: No, I think the doctors in Charleston told me that.

Q: Maybe Dr. MacCallum and Leef?

A. Well, I don't know their name, but they was five of them examined me, so–

Q: Are you taking about the Occupational Pneumoconiosis Board?

A: Yeah, in Charleston.

Q: There's a report from them back in 1984, from Drs. Recktenwald (ph.) and Hayes, from Drs. Walker, Kugel, and Pushkin.

A: It could have been them, I don't know.

Q: That's when they assessed you to have 40 percent pulmonary functional–

A: Yeah.

Q: –impairment. Did they tell you, you were disabled from black lung disease then?

A: Yes, sir, they did

Tr. 45-46.

Taking this passage in context with the rest of the miner's related testimony in the transcript, which is not reproduced here, it is evident the miner was unclear as to what he was told, by whom, and when. Given the outcome at stake, especially in light of the multiple dispositions of this case, I find that Claimant's testimony is not strong or certain enough to indicate he was informed that he was totally disabled due to pneumoconiosis within the proscribed time frame, and that Employer's counsel failed to elicit a definitive response.

In addition, Claimant's attorney's lack of inquiry into this matter on redirect is not of paramount concern here, since it is the Employer's burden to show that the claim was not timely filed. Moreover, if Employer's counsel disagreed with the form of Claimant's attorney's question, he should have objected to it at that time. Similarly, if Employer's attorney believed Claimant's answer was not responsive, he should have objected to that, as well, or perhaps have subjected the Claimant to further questioning. Instead, he made no objections and following redirect, he stated that he had nothing further. Tr. 50.

After careful consideration, I do not find the facts, testimony, and Employer's arguments sufficient to show that this claim was not timely filed. Accordingly, I find that Employer has not met its burden of rebutting the presumption of timeliness and I will proceed to analyze the remaining issues in this case.

Request for Modification

In evaluating a request for modification under § 725.310, it is not enough that the administrative law judge conduct a substantial review of the district director's finding. Rather, the claimant is entitled to *de novo* consideration of the issue. *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.*, 16 B.L.R. 1-71 (1992).

In its decision on reconsideration in *Kovac*, *supra*, the Board stated that modification proceedings based upon a mistake of fact need not be predicated on newly submitted evidence, but if a modification proceeding is based upon an alleged change in conditions, then the new evidence must be submitted in support of such allegation.

Moreover, the fact-finder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet General Shipyards, Inc.*, 404 U.S. 254, 257 (1971).

Medical Evidence

Chest X-rays

The parties stipulated to the following chest x-ray evidence:

Exhibit No.	Date of X-ray	Physician/ Qualifications	Interpretation
DX 3	1/29/81	OP Board	No ILO classification; Stereoscopic studies reveal fine irregular type nodular fibrosis in moderate amount, the result of an occupational pneumoconiosis.
DX 43	3/07/84	OP Board	No ILO classification; stereo-scopic studies reveals combi-nation of fine irregular type nodular fibrosis, the result of occupational pneumoconiosis.
DX 43	7/7/87	OP Board	No ILO classification; stereo-scopic studies reveal a combination of fine as well as course irregular type nodular fibrosis, the result of occupational pneumoconiosis.
DX 43	12/5/89	OP Board	No ILO classification; film studies reveal a nodular fibrosis, the result of occupational pneumoconiosis.
DX 15	1/17/90	Abrahams, B	Pleural abnormalities consistent with pneumoconiosis; thickening R; ? circumscribed R/B?1; thickening chest wall L/A/2; 5 mm nodule overlying 9th posterior and 6th anterior right ribs; calcified granuloma rt. upper zone.

Exhibit No.	Date of X-ray	Physician/ Qualifications	Interpretation
DX 16	1/17/90	Gaziano, B	0/0; ca
DX 33	1/17/90	Wiot, BCR, B	No cwp; probable old injury rt. acromioclavicular joint.
DX 34	1/17/90	Shipley, BCR, B	completely negative
DX 34	1/17/90	Spitz, BCR, B	completely negative
DX 98	6/7/90	Cunanan	calcified granuloma, rll field
DX 29	7/19/90	Renn, B	negative for cwp; scattered parenchymal calcifications consistent with old granulomatous disease.
DX 35	7/19/90	Wiot, BCR, B	no evidence of cwp
DX 35	7/19/90	Shipley, BCR, B	no evidence of cwp
DX 35	7/19/90	Spitz, BCR, B	no evidence of cwp
DX 39	8/15/90	Speiden, BCR, B	1/1; p/q
DX 34	8/15/90	Wiot, BCR, B	no cwp; old trauma rt acromioclavicular joint.
DX 34	8/15/90	Shipley, BCR, B	completely negative
DX 34	8/15/90	Spitz, BCR, B	completely negative
DX 94	8/15/90	Harron, B	no evidence of CWP
DX 94	8/15/90	Ranavaya, B	0/1; s/t

Exhibit No.	Date of X-ray	Physician/ Qualifications	Interpretation
DX 93	7/2/91	OP Board	No ILO classification; film studies reveal nodular fibrosis in only moderate amount, the result of occupational pneumoconiosis with no change in appearance.
DX 98	6/26/95	Cunanan	The apparent small pleural thickening along the left lateral thoracic region could be due to a nonspecific pleural thickening or this could suggest pneumoconiosis. Otherwise the lung fields appear essentially clear.
DX 87, 88	12/16/99	Burtner	chronic changes but no active intrathoracic process.
DX 105	2/14/01	Renn, B	no evidence of cwp
DX 104	2/14/01	Wiot, BCR, B	no evidence of cwp
EX 3	2/14/01	Rosenberg, B	no evidence of cwp
EX 5	2/14/01	Castle, B	no evidence of cwp
EX 7	2/14/01	Wheeler, BCR, B	no evidence of cwp
EX 8	2/14/01	Scott, BCR, B	no evidence of cwp

Pulmonary Function Studies

The parties stipulated to the following pulmonary function evidence:

Exhibit No.	Date	Age	Height	FEV1	MVV	FVC	Qualify
DX 43	8/28/79	54	70"	2.197	56	3.71	No. MVV Yes
DX 43	1/29/81	55	70"	2.16	78	3.98	No. MVV Yes
DX 43	3/7/83	58	72"	2.41	76	4.09	No. MVV Yes.
DX 43	3/26/84	59	69"	2.25	unreadable	4.35	No.
DX 43	7/3/84	59	70"	2.47	83	4.27	No.
DX 43	3/11/86	61	70"	2.14	59	3.65	No. MVV Yes.
DX 43	7/7/87	62	69"	2.24	64	3.70	No. MVV Yes.
DX 43	12/23/88	64	69"	2.18	76	3.75	No.
DX 43	12/05/89	64	69"	1.87	56	3.27	Yes.
DX 12	1/17/90	64	70"	2.01	58	3.44	No. MVV Yes.
				2.16*	57	3.41*	No. MVV Yes.
DX 29	7/19/90	65	71"	1.83	57	3.60	No. MVV Yes.
				2.33*	80*	3.96*	No.

Exhibit No.	Date	Age	Height	FEV1	MVV	FVC	Qualify
DX 30	8/15/80	65	70"	1.93	56	3.69	Yes.
				2.36*	72*	3.71*	No. MVV Yes.
DX 93	7/20/91	66	69"	1.93	57	3.62	No. MVV Yes.
DX 98	6/26/95	70	70"	2.00	71	3.52	No.
CX 1	6/26/96	71	70"	1.84	55	3.37	Yes.
				2.18*	58*	3.78*	No. MVV Yes.
DX 87, 88	12/16/99	74	70"	2.33	65	3.57	No. MVV Yes.
				2.32*	62*	3.76*	No. MVV Yes.
DX 92	12/16/99		Renn validation–valid study				
DX 87,88	2/8/00	74	70"	2.06	63	3.27	No. MVV Yes.
				2.13*	64*	3.33*	No. MVV Yes.
DX 92	2/8/00		Renn validation–valid study				
DX 105	2/14/01	75	69"	1.86	65	3.42	No. MVV Yes.
				1.91*	64*	3.67*	No. MVV Yes.
CX 2	10/10/01	76	70"	1.34	48	2.80	No. MVV Yes.
				1.91*	57*	3.33*	No. MVV Yes.

* Results post-bronchodilator

Arterial Blood Gas Studies

The parties stipulated to the following arterial blood gas evidence:

Exhibit No.	Date	pO^2	pCO^2	Qualify
DX 14	1/17/90	89.7	36.1	No
		93.5*	33.4*	No
DX29	7/19/90	99	35	No
		106*	34*	No
		104*	34*	No
DX 30	8/15/90	85	35	No
		88*	35*	No
		86*	36*	No
DX 105	2/14/01	83	32	No

*Results post-exercise

Medical and Other Reports:

Only the medical opinion evidence submitted since ALJ Levin's August 1, 1991 Decision and Order or his July 10, 1995 Decision and Order on Remand is summarized herein. All relevant evidence previously submitted is summarized in those decisions and is incorporated by reference as if fully set forth herein.

The record contains the treatment records of Dr. Roger Abrahams, dating from December 16, 1999 through October 6, 2000. (DX 87, 88) These records reveal diagnosis of industrial bronchitis with mild to moderate obstruction, osteoarthritis, hypertension and hypercholesterolemia.

Dr. Abrahams

Dr. Abrahams, board certified in internal medicine and pulmonary diseases and a B reader, reviewed the miner's medical records and submitted a report dated September 7, 2000. (DX 85) He noted that multiple pulmonary function studies revealed moderate obstructive airway disease, some of which showed significant bronchoreversibility. Most x-rays were read as showing no evidence of pneumoconiosis. He noted that Claimant is a life-long non-smoker and has no history of asthma or atopic disorders. He noted that the key issue is whether Claimant suffers from industrial bronchitis as the etiology of his moderate obstructive airways disease, or whether he suffers from asthma as the etiology. Review of medical literature and clinical evidence shows that the diagnosis of asthma is unlikely. First, he remarked that the most common asthma syndrome, atopic asthma, is characterized by childhood onset, and allergic background, neither of which is present in Claimant's history. However, Dr. Abrahams noted that although asthma can exist without a clearly identifiable allergic background, it is uncommon.

Next, he noted that in Dr. Patel's records dating from 1975 to 1990, a complete blood count in 1988 was unremarkable for eosinophils, which are an allergic cell frequently seen in asthmatic patients. Dr. Abrahams also commented that asthma is an allergic disorder with a genetic background and Claimant's medical history reveals no indication of any family history of allergic disorders. Review of medical literature indicates that coal dust exposure can cause significant obstructive airway disease irrespective of smoking habit or radiographic findings of simple coal workers' pneumoconiosis. Dr. Abrahams remarked that the fact that Claimant had significant bronchoreversibility on his pulmonary function studies is not inconsistent with chronic bronchitis, and that the airflow obstruction due to industrial bronchitis from coal dust exposure is unrelated to the presence of pneumoconiosis radiographically. Thus, patients with "normal" x-rays are equally at risk for developing obstructive airway disease from industrial bronchitis. Dr. Abrahams reiterated that it is common knowledge that asthma is an allergic disorder and that there was no reason to suspect Claimant has or had an allergic disorder, making the diagnosis of asthma unlikely. He stated that to the contrary, the only known exposure that could have caused his obstructive airways disease was his exposure to coal dust, particularly since the miner was a lifelong non-smoker. Dr. Abrahams concluded that Claimant has industrial bronchitis due to coal dust exposure as the etiology of his obstructive airway disease.

Dr. Abrahams was deposed on December 13, 2000. (DX 95) He testified that the miner was initially referred to him by physicians at West Virginia University for a pulmonary evaluation. Dr. Abrahams testified that he assessed the miner with chronic bronchitis and that the miner did not complain of a chronic cough. Dr. Abrahams stated that he did not interpret a 1997 x-ray as positive for pneumoconiosis based on an ILO classification but that it showed scattered granuloma, and that he has not found x-ray evidence of pneumoconiosis in the miner. Dr. Abrahams also stated that he found the miner to have mild-to-moderate pulmonary impairment, and that he would be able to do a considerable amount of work.

Dr. Abrahams also testified that the miner has shown improvement over the last ten years, which he attributes to chronic bronchitis being a condition that improves after the person is no longer exposed to an irritating agent. Dr. Abrahams testified that gastroesophageal reflux disease (GERD) can cause cough and nocturnal symptoms, and if the person suffers from aspiration, GERD can cause obstructive airways disease. Dr. Abrahams defined industrial bronchitis as chronic bronchitis that is due to coal dust exposure and summarized that the clinical definition is a productive cough on most days for three consecutive months for two consecutive years, and that the miner does not meet the clinical definition.

Dr. Abrahams testified that he disagrees with a diagnosis of asthma for several reasons. First, the miner does not have an atopic background or a history of being allergic and asthma without allergy is an exception. However, he also testified that there is nothing inconsistent in the miner's testing or history that is inconsistent with non-allergic asthma. Dr. Abrahams stated that there was an improvement in the miner's ventilatory capacity over the last ten years and that it is his opinion that the miner retains the pulmonary capacity to perform the exertional rigors associated with his last coal mining job.

On cross-examination, Dr. Abrahams stated that their was nothing in his notes that indicated the claimant experienced aspiration from his GERD. Dr. Abrahams also testified to a reasonable degree of medical certainty that the non-allergic asthma is not likely to be the situation with the claimant. Dr. Abrahams stated that the improvement on the pulmonary function studies is more consistent with bronchitis than asthma because the problems appeared to abate after the miner left the mines.

Dr. Abrahams also stated that the miner's level of obesity should not have any effect on his test scores. Dr. Abrahams testified that based on the previous pulmonary function data from the late eighties and 1990, the values would not indicate the ability to perform his usual coal mine work and if he were to return to the mines now, his concern is that he would redevelop the clinical aspect of the chronic bronchitis with cough and mucous production and probably have a deterioration in his pulmonary functions and would then be unable to continue working.

Dr. Abrahams submitted a supplemental report dated December 14, 2000. (DX 96) He remarked that based on pulmonary function studies performed on December 16, 1999 and February 8, 2000, Claimant is close to being disabled, but he still maintains adequate ventilatory capacity to perform his prior job. He noted, however, that if the miner were to go back into the coal mines and have recurring coal dust exposure, his chronic bronchitis would be exacerbated with increased cough and sputum production, and deterioration in his pulmonary functions. Dr. Abrahams stated that the miner actually is disabled from performing his prior coal mining job, in spite of the fact that he presently maintains adequate respiratory reserve to perform similar labor.

Dr. Renn

Dr. Joseph J. Renn, III, board certified in internal medicine, pulmonary diseases, forensic medicine, and as a forensic medical examiner and a B reader, examined the miner on February 14, 2001 and submitted a report based upon the exam and review of the miner's medical records on February 27, 2001. (DX 105) Dr. Renn recorded an employment history that consisted of underground coal mine work from 1941 until 1990, with three years layoff. He noted that the miner's coal mine work included jobs as handloader, buggy operator, sweeper and shoveler on the belt, gathering motorman, roofbolter, tipple worker, wireman, trackman, and general laborer, with the hardest part of the job consisting of lifting posts and shoveling muck. Dr. Renn remarked that the miner believes he was exposed to asbestos.

Dr. Renn recorded a history of exertional dyspnea on walking, climbing stairs and hills and carrying a 40-50 pound weight forty feet. He noted that the miner does not have exertional dyspnea with activities of daily living. He recorded an occasional cough not present on a daily basis and occasional sputum production. He recorded neither hemoptysis, sinusitis, nor postnasal drip. Dr. Renn noted that since 1990, the miner has had wheezing with an exacerbation of shortness of breath on exertion. He noted that the miner had pneumonia in 1991 but that the miner does not believe he has suffered from any other type of respiratory disease. Dr. Renn recorded that the miner has neither allergic rhinitis, conjunctivitis, or pets in the house. He has also not had paroxysmal nocturnal dyspnea, orthopnea, edema, palpitations, and either extra or skipped heartbeats. Dr. Renn recorded a history of hypertension dating to 1995, occlusion of the left vertebral artery with syncope, and a left subclavian stent placed in 1998. The miner's only other medical illnesses have been esophageal hiatus hernia with gastroesophageal reflux disease, hypercholesterolemia, and degenerative joint disease. He noted that the miner never smoked and chewed less than a pouch of tobacco daily for fourteen years. Dr. Renn also recorded the miner's family medical history.

Dr. Renn's diagnoses relating to the respiratory system include intrinsic asthma, bilateral pleural plaques and moderate obstructive ventilatory defect. He observed that a pneumoconiosis does not exist. He noted that other conditions diagnosed relating to the cardiovascular system were arteriosclerotic peripheral vascular disease and systemic hypertension. Diagnosis of the Metabolic/Endocrine system revealed exogenous obesity and hypercholesterolemia. The gastrointestinal system diagnosis were gastroesophageal reflux disease owing to esophageal hernia. Dr. Renn concluded that it is within a reasonable degree of medical certainty that the miner does not have pneumoconiosis and it is within a reasonable degree of medical certainty that his intrinsic asthma did not result from his exposure to coal mine dust. He remarked that intrinsic asthma is a disease of the general population and does not occur more frequently in those exposed to coal mine dust. Dr. Renn opined that when considering only the miner's respiratory system, he is not totally and permanently impaired to the extent that he would be unable to perform his last known coal mining job of general laborer or any similar work effort.

Dr. Renn was deposed on December 20, 2001 and testified that his assessment was that the miner has asthma. Dr. Renn stated that although in 1990 he opined that the miner had a pulmonary impairment which would prevent him from performing his usual coal mine work, he changed this opinion based on his recent evaluation because in looking at the post-bronchodilator studies over time, the miner would be able to perform the work if adequately treated. Dr. Renn further explained that the miner's ventilatory function has not decreased over time below what one would expect for the aging process. In addition, he stated that looking at the post-bronchodilator study performed by Dr. Abrahams in October 2001, the values indicate the miner had the capacity to perform the rigors of his usual coal mining work, with the values being above what one would expect from a coal mine dust induced disease process.

Dr. Renn explained that there is no bronchoreversibility in a coal mine dust induced impairment and there is a specific pattern in which there can be a degree of restriction, a degree of obstruction, or a mixed pattern but no bronchoreversibility. He remarked that he does not recall reading in the literature associated with coal dust exposure about bronchoreversibility or significant reversibility, and that this is consistent with his years of experience treating coal miners. Dr. Renn criticized Dr. Koenig's November 5, 2001 report, stating that Dr. Koenig's definition of COPD is overbroad and he cites the definition of asthma from a six chapter article entitled, "The Standards for the Diagnosis and Care of Patients with Chronic Obstructive Pulmonary Disease (COPD) and Asthma." Dr. Renn explained that he cited this definition because Dr. Koenig only considered smoking and coal mine dust exposure as risk factors for COPD which is incorrect, as the article lists multiple other risk factors including ambient air pollution, race, and socioeconomic factors. Dr. Renn then goes on to cite two more studies for the same proposition that Dr. Koenig did not entertain other risk factors.

Dr. Renn disagreed with Dr. Koenig when he stated in his report that "the airflow obstruction associated with asthma is classically completely reversible," and cited a 1971 NIH expert panel report indicating that there is not reversibility in a number of patients with asthma, especially older patients. In addition, Dr. Renn remarked that an article relied on by Dr. Koenig has no direct relation to Claimant's situation because 96.5% of the study subjects were smokers, unlike the claimant. Dr. Renn testified that he selected a study that was actually performed on people greater than age 60 who were lifelong nonsmokers. He explained that this study showed that asthma in the older individual can be non-allergic, and leads to airway remodeling and an irreversible portion of airway obstruction.

Dr. Renn testified that he believes Claimant has asthma based on his episodic exertional dyspnea, and episodic wheezing. He explained that the miner has essentially a nonproductive cough and his wheezing causes exacerbation of his shortness of breath, which is typical of asthma. Dr. Renn also explained that the miner has been treated for gastroesophageal reflux disease, which is well known to be associated with asthmatics–present in about 40% of asthmatics. Dr. Renn testified that there is no evidence of COPD or emphysema on Claimant's

chest x-ray. Dr. Renn testified that Dr. Abrahams' recent records don't show history of productive cough and that the miner does not have evidence of chronic bronchitis and his occasional cough and sputum production are consistent with asthma. He also noted that Dr. Abrahams' treatment is consistent with the treatment rendered for an asthmatic.

Dr. Renn testified on cross-examination that although he has found the existence of pneumoconiosis without positive chest x-ray, this is in very few cases. He explained that minus positive x-ray indications, he would look for a history of exposure and no cofounders that would suggest an alternative explanation, and patients with a pathophysiologic pattern consistent with coal workers' pneumoconiosis. Dr. Renn explained that one of the factors he would look for would be a reduction in total lung capacity, that would go along with a restrictive process. Other cofounders would include recurrent history of pneumonias, smoking, and asthma.

When asked, Dr. Renn stated that assuming coal miners are included in the general population, asthma would be represented in about 15 to 18 percent of the general population. Dr. Renn also responded that he finds impairment associated with pneumoconiosis about one percent of the time. Dr. Renn responded that he agrees that there is a discrepancy between the findings of pneumoconiosis by x-ray and the findings on autopsy after death, and the range of discrepancy by plain x-ray is about 33 percent. Dr. Renn stated that he attributed the fact that none of the post-bronchodilator studies are normal to airway remodeling or inadequate treatment for two years, in part because the miner wasn't given the appropriate treatments over the appropriate periods of time and because he was noncompliant with his treatment regimens.

Dr. Branscomb

Dr. Ben V. Branscomb, board-certified in internal medicine and a B-reader, reviewed the miner's medical records and submitted a report dated June 28, 2001. (EX 1) Dr. Branscomb first noted that there has been sufficient coal mine exposure so that assuming the necessary sensitivity, Claimant could acquire CWP or some adverse pulmonary effect. Dr. Branscomb further noted that the miner never smoked and that he had a history of hiatus hernia with esophageal reflux syndrome, which he stated is an important risk factor for chronic bronchitis. He noted the Claimant had rather severe obesity, which he explained is important because obesity tends to increase x-ray markings, increases shortness of breath of any etiology, and predisposes to gastric aspiration.

Dr. Branscomb noted that the chest examinations were usually negative, although Dr. Jaworski heard wheezing in 1990. He remarked that the x-rays have almost all been negative for CWP and there is no radiographic support for a diagnosis of the medical disease coal workers' pneumoconiosis. Dr. Branscomb remarked that pulmonary function tests, coupled with the opinions of the miner's various examining doctors, confirms the presence of an obstructive airways disease, variable in intensity both spontaneously and in response to treatment but not

progressing. He also noted that the arterial blood gases have all been normal and have shown increased oxygen tensions with exercise. Dr. Branscomb also opined that there is no medical pneumoconiosis and that Claimant is not totally disabled from coal mining by virtue of his chronic pulmonary disease which is based on his very stable COPD over so many years. He stated that it is his opinion that the miner has intrinsic bronchial asthma.

Dr. Branscomb observed that there was disagreement among the examiners pertaining to the diagnosis of asthma. Specifically, he explained the majority of patients who have asthma do not have allergy or childhood onset. He commented that more patients are now diagnosed for the first time with asthma during adulthood than during childhood. Thus, the absence of known allergies and the onset during adulthood in Claimant are the common circumstances for adult asthma. Dr. Branscomb remarked that Dr. Rasmussen "correctly pointed out that the critical finding in chronic bronchitis is persistent cough and expectoration–not wheezing and airways reversibility (although there is usually some reversibility in chronic bronchitis)." He explained that a reading of the miner's medical reports does not describe a pattern of continuous disturbing cough with expectoration of viscous inflammatory exudate. Dr. Branscomb opined that the lack of a history of attacks brought on upon going into the mine plus the persistence of the disorder for so many years with stable symptoms since leaving the mine rules out occupational asthma. He opined that Claimant does not have industrial bronchitis or chronic bronchitis caused by dust exposure, but has mild chronic stable pulmonary disease which is mild asthma. He concluded that the miner has no pulmonary disorder or impairment either caused by or significantly aggravated by exposure to coal mine dust.

Dr. Fino

Dr. Gregory J. Fino, a B-reader who is board-certified in internal medicine and pulmonary disease, reviewed additional medical records and submitted a supplemental report dated July 15, 2001. (CX 8) Dr. Fino stated that the purpose of the review was to determine whether an occupational pneumoconiosis is present and to determine whether or not a respiratory impairment or disability is present. Dr. Fino summarized the definition of pneumoconiosis and noted that each condition and disease included in the definition manifest different clinical and pathologic signs and characteristics, and "since these conditions are distinct from each other, generalizations about 'pneumoconiosis' cannot be made."

Dr. Fino opined that the miner does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. He noted that this is based on:

1) The majority of chest x-ray readings are negative for pneumoconiosis.
2) The results of the pulmonary function studies are consistent with asthma.
3) The diffusing capacity values are normal. A normal diffusing capacity rules out the presence of clinically significant pulmonary fibrosis. Pneumoconiosis is an example of pulmonary fibrosis.
4) There is no impairment in oxygen transfer as this man does not become hypoxic with exercise.

Dr. Fino further opined that from a functional standpoint, the miner's pulmonary system is abnormal and he does not retain the physiologic capacity, from a respiratory standpoint, to perform all of the requirements of his last job. He noted that there are two risk factors for this disability–coal mine dust exposure and asthma. Dr. Fino remarked that in this instance, the clinical information is consistent with an asthma related disability.

Dr. Fino concluded that there is insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis. It is Dr. Fino's opinion that the miner does not suffer from an occupationally acquired pulmonary condition but there is a disabling respiratory impairment present due to asthma. Dr. Fino stated that even if he were to assume the miner has medical or legal pneumoconiosis, it has not contributed to his disability and he would be as disabled had he never stepped foot in the mines.

Dr. Rosenberg

Dr. David Rosenberg, board certified in internal medicine, pulmonary disease, occupational medicine, and a B-reader, reviewed the medical records and submitted a report dated July 26, 2001. (EX 3) Dr. Rosenberg stated that based on a review of the information, it can be appreciated that Claimant has normal oxygenation and gas exchange on multiple occasions with exercise. He explained that this is probably the best way to determine whether or not there is any destruction of the alveolar capillary bed consequent to the presence of interstitial fibrosis. He stated that Claimant's normal gas exchange indicates he does not have interstitial lung abnormalities and that this is supported by the fact that his chest x-rays have been read by the majority of B readers as being negative for the presence of coal workers' pneumoconiosis. Dr. Rosenberg stated that clearly, the miner does not have this type of occupational lung disease.

Dr. Rosenberg observed that the miner has a degree of chronic obstructive pulmonary disease which would best be characterized as a mild-moderate degree of airflow obstruction with a degree of bronchoreversibility. He opined that Claimant is not totally disabled from a respiratory perspective, and could perform his previous forms of coal mining employment. He

noted that the miner's chronic obstructive pulmonary disease probably relates to asthmatic diathesis. Dr. Rosenberg concluded that coal dust exposure would not have caused clinically significant airflow obstruction as has been evident in Claimant. Dr. Rosenberg stated with a reasonable degree of medical certainty that the miner does not have CWP and could perform his previous coal mine work or other similar types of employment activities. He concluded that any impairment the miner has is not related to the inhalation of coal mine dust or the presence of CWP but probably relates to an asthmatic tendency.

Dr. Castle

Dr. James Castle, board certified in internal medicine and pulmonary diseases and a B-reader, reviewed the miner's medical records and submitted a report dated September 13, 2001. (EX 5) He concluded that Claimant does not suffer from coal workers' pneumoconiosis. Dr. Castle remarked that the miner worked in or around the underground coal mining industry for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host. He noted that the miner was a lifelong nonsmoker. He observed that the miner had episodic nocturnal wheezing but did not have a chronic, ongoing problem with productive cough and sputum production, and also had evidence of gastroesophageal reflux disease which may induce bronchospasm and coughing. Dr. Castle stated that at no time did Claimant demonstrate any physical findings on a consistent basis that would indicate the presence of an interstitial pulmonary process such as coal workers' pneumoconiosis. He noted that Claimant did not have a consistent finding such as rales, crackles, or crepitations and most pulmonary exams were unremarkable.

Dr. Castle also noted that the physiologic studies showed evidence of either a mild or mild-moderate degree of airway obstruction which on some occasions demonstrated a very significant degree of reversibility and these changes remained very stable over a number of years. He further noted that there was a waxing and waning of the degree of obstruction with time and treatment over time; a finding that is characteristic of an individual who has adult onset or intrinsic bronchial asthma and not typical of coal workers' pneumoconiosis including industrial bronchitis. Dr. Castle explained that industrial bronchitis is a condition that occurs with ongoing exposure to an inert particle such as coal dust and that this condition results in a mild degree of airway obstruction which does not respond to bronchodilator therapy. Further, Dr. Castle explained, this condition is self-limited and abates within six months or so after leaving the mining industry, and is primarily manifested by cough with significant sputum production on a daily basis. Dr. Castle noted that the arterial blood gases have been normal and when exercise was performed, there was a normal response to exercise. He also noted that there was no abnormality of blood gas transfer mechanisms.

Dr. Castle stated that he would agree with both Dr. Abrahams and Dr. Renn when they indicated that the miner is not permanently and totally disabled from a pulmonary point of view. He noted that Dr. Abrahams later indicated that the miner was disabled because of coal dust exposure but did not indicate disability due to respiratory disease. He stated that it is also his opinion that Claimant may be disabled as a result of atherosclerotic peripheral vascular disease or other medical problems which are not related to the inhalation of coal mine dust. He observed that the physiologic studies showed evidence of either a mild or mild to moderate degree of airway obstruction, which on some occasions demonstrated a very significant degree of reversibility. He commented that the findings are characteristic of an individual who has adult onset or intrinsic bronchial asthma. He remarked that as has been noted by other reviewers, this condition does not require an atopic or allergy history, and in fact, this condition is more common in those who do not have an allergy history. He noted that these findings are not typical of coal workers' pneumoconiosis including industrial asthma.

Dr. Castle remarked that while some degree of reversibility is certainly seen in patients with chronic obstructive pulmonary disease, i.e. chronic bronchitis, the variability is seen in the specific case over time and treatment and the significance of the reversibility, which leads him to conclude that the miner's pulmonary condition is that of adult onset bronchial asthma or intrinsic asthma. He remarked that nevertheless, Claimant does not demonstrate a pulmonary disability which would preclude him from returning to his usual coal mine employment duties from any cause. Dr. Castle concluded that Claimant is not permanently and totally disabled as a result of any pulmonary process including coal workers' pneumoconiosis and based upon the respiratory data, it is his opinion that Claimant does retain the respiratory capacity to perform his previous coal mining employment duties.

Dr. Castle was deposed on December 11, 2001. Dr. Castle testified that Claimant does not retain the capacity from a pulmonary standpoint to perform his previous coal mine work. Dr. Castle stated that he realizes that this opinion is at variance with what he stated in his report, but that upon reviewing the most recent data he was provided, he doesn't believe the miner retains the respiratory capacity to do the work of a general inside laborer, because he has very significant airway obstruction with a very significant or marked degree of reversibility.

In his testimony, Dr. Castle defined chronic bronchitis and industrial bronchitis both as a chronic cough productive of sputum for at least three months out of the year for two consecutive years, with industrial bronchitis being associated with industrial dust exposure. He testified that the miner does not exhibit symptoms of either condition and when he was seen most recently by Dr. Abrahams, he did not report a chronic productive cough or any significant sputum production, nor any exposure to inert dust for a long period of time. Pertaining to asthma, Dr. Castle also explained that in children, complete reversibility with a bronchodilator is expected, but adults undergo a process called airway remodeling, a term describing asthma which develops

or includes fixed airway obstruction. He further explained that the progression of the disease can be reduced with the proper use of asthma medications; failing this ongoing therapy, patients will have continuing inflammatory process resulting in the slow, insidious progression of their disease with fixed airway obstruction.

Dr. Castle testified that the miner had no evidence of a restrictive impairment and that there has not been any change of significance in the miner's lung condition during the studies in the late 70's or early 80's through the present time. Dr. Castle also testified that although Dr. Abrahams diagnosed the miner with industrial bronchitis and irreversible airway obstruction, he started the miner on Advair, a long-acting bronchodilator, whose only indication is for bronchial asthma. Dr. Castle testified that although he doesn't disagree that the miner has obstructive airways disease, he diagnosed asthma for a number of reasons.

First, the miner has a history of intermittent shortness of breath and wheezing which is a symptom found in bronchial asthma and the symptoms occur with exertion and nocturnally. Dr. Castle explained that asthmatics have more problems nocturnally, as opposed to the chronic bronchitic. In addition, the miner has markedly reversible bronchospasm and the extent of the reversibility in this case far exceeds that seen with chronic bronchitis. Third, Dr. Castle notes, the miner has gas trapping, which occurs in people with asthma and he doesn't have hyperinflation. Next, he stated the miner has an increased diffusing capacity of carbon monoxide that is absolutely atypical for either tobacco smoke induced chronic lung disease or coal mine induced chronic lung disease–a finding not generally seen in coal mine dust induced lung disease, yet a typical finding in people with asthma who are not status asthmaticus. Further, he noted that the miner has a normal chest x-ray and he did not have chronic productive cough with sputum production. Dr. Castle explained that one thing seen in coal mine induced airways disease is a chronic productive cough that is generally ameliorated upon leaving the mining industry. Dr. Castle also remarked that the miner had no evidence of bronchospasm associated with chronic infection. Finally, Dr. Castle explained that while the miner has no history of atopy or childhood asthma, most adults with asthma don't have that and the allergic mediated asthma is much more common in young adults and children. Dr. Castle further explained that the miner's adult onset asthma has not been adequately treated, causing him to develop some fixed airway obstruction, as a result of airway remodeling or scarring developing, so that he doesn't get total reversibility with medications.

Dr. Castle testified that he disagreed with Dr. Koenig's opinion that asthma is classically completely reversible and noted that this was thought to be true 30 years ago. Dr. Castle stated that in his experience, airways diseases associated with coal dust exposure do not significantly respond to bronchodilator medications, and the patients he personally cares for with airway obstruction due to their coal mine induced lung disease are not responsive to bronchodilators. Dr. Castle testified that even if the miner's x-ray were interpreted as showing simple pneumoconiosis, of a category of 1/0, his assessment as to the etiology of the miner's disease would not change because the miner does not have the physiologic changes, or the symptoms, or the other findings consistent with that.

Dr. Rasmussen

Dr. D.L. Rasmussen, board-certified in internal medicine and forensic medicine, reviewed the medical records and submitted a report dated October 29, 2001. (CX 4) Dr. Rasmussen noted that all of the pulmonary function studies to date indicate at least a mild degree of ventilatory impairment considering the post bronchodilator values. This degree of impairment, he concluded, would preclude Claimant from performing heavy to very heavy manual labor, such as his self-described previous employment. Dr. Rasmussen based this conclusion on the fact that heavy work would consist of work loads requiring an oxygen consumption of 20-25 cc/kg/min and in his examination of the miner in August 1990, the miner achieved an oxygen uptake of 18.6 cc/kg/min. Dr. Rasmussen also remarked that the post-bronchodilator degree of improvement would be consistent with hyperactive airways disease which could be the consequence of bronchial asthma or otherwise chronic airway obstruction with superimposed acute or subacute bronchial infections and it also could possibly be related to relatively recent inhalation of irritating gases.

Dr. Rasmussen noted that Claimant has at least a mild degree of ventilatory impairment which would prevent him from performing his last regular coal mine job with its attendant requirement for heavy and very heavy manual labor. He noted that Claimant does not give a clinical history that is suggestive of bronchial asthma; therefore, asthma intrinsic or otherwise is no more likely than recurrent respiratory infections or inhalation of strong odors. Dr. Rasmussen explained that although the vast majority of the miner's x-ray interpretations have been negative for opacities consistent with coalworkers' pneumoconiosis, in none of the epidemiologic studies has there been shown an association between the loss of ventilatory capacity and radiographic evidence of pneumoconiosis and significant loss has been shown in miners absent x-ray abnormalities. Dr. Rasmussen opined to a reasonable degree of medical certainty that the miner's loss of lung function is the consequence of his coal mine dust exposure and that Claimant suffers from a degree of impairment in lung function which prevents his performance of his last regular coal mine job with its attendant requirement for heavy and very heavy manual labor. He further concluded that this loss of lung function can be attributed to his previous significant coal mine dust exposure.

Dr. Koenig

Dr. Steven Koenig, board certified in internal medicine, pulmonary disease, critical care medicine, and sleep medicine, reviewed the medical records and provided a report dated November 5, 2001. (CX 6, 7) He noted that the miner's coal dust exposure was of sufficient intensity and duration (approximately 25 years) to cause respiratory impairment in a susceptible individual. He concluded that Claimant has pulmonary impairment secondary to obstructive lung disease, and is totally and permanently disabled from his respiratory disease. Dr. Koenig compared the opinions of the other physicians, and agreed with Drs. Rasmussen, Abrahams, and

Rosenberg that the preponderance of the objective evidence indicates that Claimant has COPD and not asthma. Dr. Koenig noted that although Drs. Renn, Branscomb, and Fino cite improvement in spirometry after a beta-adrenergic agonist and variability in pulmonary function as definitive evidence of asthma, this conclusion is incorrect.

Dr. Koenig explained that significant improvement in FEV1 after beta-adrenergic agonists has been observed in up to 1/3 of COPD patients in single testing sessions and up to 2/3 in serial testing. He further explained that "reversibility" is so common that the term "asthmatic bronchitis" has been coined to describe such individuals. Dr. Koenig also explained that the presence of incomplete reversibility of airflow obstruction with bronchodilator favors the diagnosis of COPD over asthma, in that airflow reversibility in asthma is classically completely reversible.

Dr. Koenig remarked that the miner's obstructive lung disease is caused by COPD, which includes chronic bronchitis and emphysema. He noted that the miner does not have asthma; however, even if he should have asthma, COPD contributed significantly to his obstructive lung disease and consequent pulmonary impairment. He noted that the miner is a non-smoker and therefore, coal dust exposure alone, even without evidence of simple or complicated CWP on chest x-ray and pulmonary function testing, was the cause of his COPD and resultant permanent and total disability. Dr. Koenig commented that to claim that Claimant's COPD could not be secondary to coal dust exposure would be disregarding numerous methodologically valid studies in the medical literature as well as opinions set forth by NIOSH, the Industrial Injuries Advisory Council of Great Britain (IIAC), and numerous experts in the field of occupational lung disease. Dr. Koenig concluded that coal dust exposure is a cause of the miner's COPD.

Conclusions of Law

Applicable Regulations

Claimant's claim for benefits was filed on December 6, 1989 and is governed by the Part 718 Regulations. However, on January 19, 2001, substantial changes to Parts 725 and 718 of the Federal Regulations became effective. Based upon my review of the new Regulations, there are two sections that specifically deal with the question of whether these new Regulations are applicable to cases that are currently pending at the time of the enactment.

Pursuant to § 725.2(c) the revisions of this part [Part 725] shall also apply to the adjudication of claims that were pending on January 19, 2001, except for the following sections: § 725.309, 725.310, etc. (see the C.F.R. for the complete list of exempted sections). Accordingly, with the exception of those sections listed as an exemption, the revisions to Part 725 will apply to the facts of this decision.

Pursuant to § 718.101(b) the standards for the administration of clinical tests and examinations contained in subpart B "shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part [718]..." (emphasis added). Accordingly, since the evidence in the instant matter was developed prior to January 19, 2001, the newly enacted § 718, subpart B does not apply.

On August 9, 2001, U.S. District Court Judge Emmet Sullivan upheld the validity of the new Regulations in *National Mining Association v. Chao*, No. 00-3086 (D.D.C. Aug. 9, 2001). However, on June 14, 2002, the United States Court of Appeals for the District of Columbia Circuit ("the court") affirmed in part, reversed in part, and remanded the case. *See National Mining Association v. Department of Labor*, No. 01-5278 (June 14, 2002). Accordingly, I will apply the sections of the newly revised version of Part 718 (i.e. subparts A, C and D) and 725 that took effect on January 19, 2001 that the court did not find impermissibly retroactive to the facts of the instant matter.

Length of Coal Mine Employment

The parties stipulated and I find that Claimant was a coal miner within the meaning of the Act for at least 21 years. Tr. 35.

Dependents

The Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Velda. Tr. 35.

Responsible Operator

The parties have stipulated and I find that Consolidation Coal Company is the responsible operator and will provide for the payment of any benefits awarded to the claimant. Tr. 35.

Existence of Pneumoconiosis

Claimant's claim was previously denied because he failed to establish that he suffers from pneumoconiosis or that he is totally disabled from pneumoconiosis. All of the evidence must be considered to determine whether pneumoconiosis or total disability due to pneumoconiosis can now be established or a mistake in a determination of fact was made.

The definition of pneumoconiosis includes both clinical and legal pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, including, but not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrasilicosis, massive pulmonary fibrosis, or silicotuberculosis, arising out of coal mine employment. § 718.201(a)(1). "Legal pneumoconisis" includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. § 718.201(a)(2). A disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. § 718.201(b).

The Regulations provide four methods for finding the existence of pneumoconiosis: 1) chest x-rays; 2) autopsy or biopsy evidence; 3) the presumptions in §§ 718.304, 718.305, and 718.306, and 4) the medical opinion of a physician exercising sound medical judgment and based on objective medical evidence. As there is no autopsy or biopsy evidence in this case and Claimant is not eligible for the enumerated presumptions, he must rely on chest x-rays and medical opinions to establish the existence of pneumoconiosis.

The record contains 29 interpretations of twelve x-rays. Seven of the interpretations are positive for pneumoconiosis, 21 of the interpretations are negative, and one interpretation, by Dr. Cunanan, is equivocal. Of the seven positive interpretations, four do not conform with the classification requirements set forth in § 725.102(b). An administrative law judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co*., 14 B.L.R. 1-70 (1990). *See also Tokaricik v. Consolidation Coal* Co., 6 B.L.R. 1-666 (1984)(the judge properly assigned greater weight to the positive x-ray evidence of record, notwithstanding the fact that the majority of x-ray interpretations in the record, including all of the B-reader reports, were negative for existence of the disease).

Where two or more X-ray reports are in conflict, the radiological qualifications of the interpreting physicians shall be considered. § 718.202(a)(1). Additionally, the interpretations of the physicians dully-qualified as board-certified radiologists and B readers are entitled to more weight than the interpretation of B readers. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128 (1984). Twelve of the x-rays were interpreted as negative for pneumoconiosis by the dually-qualified physicians and one as positive by a dually-qualified physician. Further, seven of the x-rays were interpreted as negative by B readers and one as positive by a B reader. After weighing the qualifications of the positive readers to the negative readers, I find that the vast majority of the more qualified physicians interpreted the twelve x-rays as negative for pneumoconiosis.

In view of the foregoing, I find that the preponderance of the x-ray evidence is negative for pneumoconiosis.

Pneumoconiosis may also be established by a physician, exercising sound medical judgment, based upon clinical data and medical and work histories, and supported by a reasoned medical opinion, finding that the miner suffers from pneumoconiosis as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a).

An unreasoned opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physicians conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based his diagnosis. *Fields, supra*. An opinion may be adequately documented if it is based on items such as physical examinations, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1987). Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder of fact to decide. *Clark, supra*.

There is no disagreement among the physicians' opinions that the claimant has a chronic obstructive pulmonary disease (COPD); however, the crux of the debate is whether the obstructive disorder is related to dust exposure from his coal mine employment. Drs. Abrahams, Rasmussen, and Koenig opined that the miner's obstructive airway disease is a result of occupational exposure. Drs. Renn, Branscomb, Fino, Rosenberg, and Castle, on the other hand, opined that the miner's obstructive airway disease is a result of asthma.

All of these most recent physicians rendered opinions based on the claimant's medical histories, the physical examinations, and test results. Thus, I find all of these opinions to be documented. Regarding their reasoning, all of the physicians acknowledge that the x-ray evidence is essentially negative for pneumoconiosis and their opinions do not differ on this basis. Alternatively, the physicians do differ in their reasoning as to the basis of the miner's obstructive airway disease; specifically, whether the miner suffers from an occupational lung disease or asthma.[4] Of these opinions, I find the opinions of Drs. Castle, Renn, and Branscomb to be better supported in light of the miner's overall medical record than those of Drs. Abrahams, Rasmussen, and Koenig.

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[4] Asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). The Department's comments to the revised regulations address chronic obstructive pulmonary disease in general, and emphysema and bronchitis specifically. There is no departmental finding that coal dust can be a causative factor of asthma specifically. In fact, no study on asthma is mentioned. 65 Fed. Reg. 79,937 to 79,945 (Dec. 20, 2000).

I accord less weight to the opinion of Dr. Rasmussen, who states that, "the post-bronchodilator degree of improvement would be consistent with hyperactive airways disease which could be the consequence of bronchial asthma or otherwise chronic airway obstruction with superimposed acute or subacute bronchial infections and it also could possibly be related to relatively recent inhalation of irritating gases." Dr. Rasmussen then states that the miner does not give a clinical history suggestive of asthma, but doesn't state what in the history led him to this conclusion. Moreover, he concludes by stating that the miner's loss of lung function can be attributed to his previous significant coal mine dust exposure but again doesn't explain what let him to this conclusion. Thus, I find that his opinion is not well-reasoned.

I also accord less weight to the opinions of Drs. Abrahams and Koenig, as their opinions do not appear as carefully considered as the other physicians. Although Dr. Koenig states that the preponderance of the evidence indicates that the claimant has COPD and not asthma, he doesn't explain what in the miner's medical records led him to this conclusion, other than the fact that the Claimant worked in the mine and didn't smoke. Additionally, unlike Drs. Castle, Renn, and Branscomb, Dr. Koenig did not discuss the miner's history of esophageal reflux syndrome or his obesity, the first of which is a risk factor of chronic bronchitis and occurs in 40% of asthmatic patients, and obesity, as explained by Dr. Branscomb, tends to increase x-ray markings, increase shortness of breath of any etiology, and predisposes a patient to gastric aspiration. Finally, Drs. Abrahams and Koenig do not discuss the miner's most recent medical history as part of the miner's entire condition, unlike Drs. Renn and Castle.

Specifically, Dr. Castle testified that there has not been any change of significance in the miner's lung condition during the studies in the late 70's or 80s through the present time and that the miner did not report a productive cough or significant sputum production during his most recent exam with Dr. Abrahams. This is consistent with the majority of medical records in which the miner consistently reports more of a wheezing type of cough with little sputum production.

In addition, Dr. Renn explained that the miner's ventilatory function has not decreased over time below that expected for the normal aging process, and the October 2001 ventilatory values were above what one would expect from a coal mine dust induced disease. Moreover, in his December 14, 2001 report, Dr. Abrahams himself states that although Claimant is close to being disabled, he still maintains adequate ventilatory capacity to perform his prior job, which could actually indicate an improvement in the miner's condition. I note that all of these statements are inconsistent with pneumoconiosis, which is a latent and progressive disease § 718.201(c), and has also been described as a progressive and irreversible disease. *Eastern Associated Coal Corp., v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000), *citing Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987).

I also accord less weight to the opinions of Drs. Fino and Rosenberg. Dr. Fino essentially disagrees with the definition of legal pneumoconiosis and Dr. Rosenberg states that the miner's condition "probably relates to asthmatic diathesis" but does not explain what causes him to arrive at this conclusion.

Finally, I consider both Dr. Castle's and Dr. Renn's reports and deposition testimonies to be the best reasoned discussions of the miner's condition and accord them the greatest weight. Dr. Castle thoroughly discusses the miner's medical records, and explains in a step by step manner in his deposition testimony precisely how he would go about diagnosing the miner, and what led him to his ultimate conclusion that the miner suffers from adult onset asthma, not occupational in nature, while still considering the alternative opinions of the other physicians. Dr. Renn also thoroughly explains the basis for his opinion that the miner suffers from adult onset asthma with precise elements from the miner's physical examinations, medical history and complaints, and the objective test evidence.

Therefore, I find that Claimant has failed to establish pneumoconiosis by the preponderance of the medical opinion evidence pursuant to § 718.204(a)(4). As pneumoconiosis is not shown under any of the provisions of § 718.202(a)(1)-(4), the claimant has not established that he suffers from pneumoconiosis. Moreover, in considering the new evidence of record along with the prior evidence of record, I find that there has been no mistake of fact or change in condition with respect to ALJ Levin's earlier finding that the claimant does not suffer from pneumoconiosis.

Existence of Total Disability

In order to establish entitlement to benefits under the Act, a miner must prove that he is totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a). Total disability is defined as the inability of the miner to perform his usual coal mine work and comparable gainful employment in the immediate area of the miner's residence.

A finding of total disability may be based on the criteria found in § 718.204(b)(1), which provides that a miner will be considered totally disabled if the irrebuttable presumption set forth in § 718.304 applies, or may be established by the criteria set forth in § 718.204(b)(2), which consists of qualifying pulmonary function studies, qualifying blood gas studies, the existence of cor pulmonale with right sided congestive heart failure, and the opinion of a physician, exercising sound medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluding that the miners pulmonary condition prevents him from performing his usual coal mine work.

The record contains twenty-one pulmonary function studies, four of which have pre-bronchodilator qualifying results. I conclude that Claimant has not established total disability by the pulmonary function study evidence pursuant to § 718.204(b)(2)(i).

The record also contains four arterial blood gas studies, none of which are qualifying, either pre- or post-exercise. Thus, Claimant has not established total disability via the blood gas study evidence pursuant to § 718.204(b)(2)(ii).

There is no evidence that Claimant suffers from cor pulmonale with right-sided congestive heart failure pursuant to § 718.204(b)(2)(iii).

Of the medical opinion evidence of record, I note first that in ALJ Levin's Decision and Order, all of the physicians agreed the claimant has a totally disabling respiratory impairment, and the central issue in the case was the etiology of Claimant's disability. (DX 56, 67) Of the newly submitted evidence, four physicians, Drs. Fino, Castle, Rasmussen, and Koenig opined that the miner is disabled from performing his previous coal mine work. Dr. Abrahams' opinion initially states that the miner would be disabled in the future if he returns to the mine, but ultimately he concludes that, "I believe within a reasonable degree of medical certainty that he actually is disabled from performing his prior coal mining job, in spite of the fact that he presently maintains adequate respiratory reserve to perform similar labor." Three physicians, Drs. Renn, Branscomb, and Rosenberg concluded otherwise.

I find that the opinions of Fino, Castle, and Rasmussen, and Koenig better reasoned than those of Drs. Renn, Branscomb, Rosenberg, and Abrahams. First, I consider Dr. Rosenberg's opinion stating that Claimant "is probably not disabled on a pulmonary basis from work equivalent to his previous coal mine jobs" to be equivocal. Moreover, his report does not indicate that he considered the character of Claimant's position as a general inside laborer.

Dr. Branscomb's opinion is also equivocal. He states that claimant is "probably not disabled on a pulmonary basis from work equivalent to his previous coal mine jobs."

Dr. Renn's opinion is inconsistent with his earlier testimony in which he found the miner to be disabled from his last coal mining job and I find his subsequent deposition testimony explaining the basis for his change in opinion to be unsatisfactory. Therefore, I accord his opinion less weight.

Dr. Abrahams' opinion is contradictory, in that he states that the miner is disabled from performing his previous coal mine job, but is able to currently perform "similar labor." This "similar labor" is the equivalent of the "comparable work" set forth in the regulations. Therefore, his opinion is entitled to less weight.

I find that the preponderance of the better reasoned medical opinion evidence, together with ALJ Levin's Decision and Orders, establish that the miner is totally disabled from a pulmonary standpoint from performing his previous or comparable coal mine work, notwithstanding the generally negative pulmonary function and arterial blood gas tests. In arriving at this conclusion, I note that after weighing the tests and medical opinions together, I find the medical opinions more compelling. All of the physicians addressed the test results, but the physicians submitting the better reasoned opinions still found the miner totally disabled in spite of them, and provided thorough explanations as a basis for their conclusions.

Disability Causation

The final issue to be determined is whether Claimant has established disability causation at § 718.204 (c)(1). As Claimant has not established that he suffers from pneumoconiosis, he cannot establish that his totally disabling respiratory impairment is caused by it.

Conclusion

Claimant has failed to prove that he has pneumoconiosis and that his total disability is due to pneumoconiosis; therefore he has not established entitlement to benefits under the Act. As Claimant failed to establish a mistake in fact or a change in condition, his claim for benefits must be denied.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

ORDER

IT IS THEREFORE ORDERED THAT:

The claim of Clarence O. Crites for benefits under the Act is DENIED.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.